



Behavioral Health Crisis Response Stakeholder Coalition (BHCRC)

Minutes | Meeting 2

Tuesday, May 25, 2021

1 pm – 5 pm

Virtual Meeting via Zoom

Meeting Outcomes:

- Refresher of core planning concepts
- Report-outs from workgroup discussions, and high-level theming of discussions to date
- Introductions to technical assistance providers, and review of their scopes of work to support bed registry and financial modeling components of this work
- High-level introduction to current crisis response assessment and visioning for the future

For More Information:

- DSS Funding Opportunities | 988 Planning Grant (scroll to the bottom of the page): <https://dss.sd.gov/behavioralhealth/grantinfo.aspx>
- [Meeting #2 Recording](#)

Opening Remarks:

The second meeting of the Behavioral Health Crisis Response Stakeholder Coalition (BHCRC) was called to order by Tiffany Wolfgang, Director for the Division of Behavioral Health (DBH), South Dakota Department of Social Services (DSS). Wolfgang welcomed the assembled group of coalition members and state support staff to the meeting. Introductions of new BHCRC members as well as those unable to join the kickoff meeting were made. Those attending the meeting included:

- Laura Ringling, DBH Chief, DSS
- Tiffany Wolfgang, DBH Director, DSS
- Bre Baltzer, Behavioral Health Registry Lead within DBH
- Tessia Johnston, Prevention Program Administrator, DSS
- Jana Boocock, Prevention Program Manager and State Suicide Coordinator, DSS
- Tara Johanneson, individual with lived experience
- Penny Kelly, individual with lived experience
- Rosanne Summerside, individual with lived experience
- Matthew Glanzer, individual with lived experience
- Janet Kittams, CEO, Helpline Center
- Taylor Funke, Substance Use Program Manager, Helpline Center
- Kiley Hump, Administrator for the Office of Chronic Disease and Health Promotion, South Dakota Department of Health (DOH)
- Thomas Otten, Vice President, Avera Behavioral Health
- Katherine Sullivan, Director of Behavioral Health Services, Monument Health
- Jeremy Johnson, Administrator, Human Services Center
- Kris Graham, CEO, Southeastern Behavioral Health Care
- Amy Iversen, CEO, Capital Area Counseling Service
- Staci Ackerman, Executive Director, South Dakota Sheriffs Association
- Dave Kinser, Grants & Accreditation Manager, Rapid City Police Department

- Maria King, Statewide 911 Coordinator
- Aimee Chase, Deputy Director, Metro Communications (911)
- Wendy Giebenk, Executive Director for NAMI in South Dakota
- Kelli Rumpza, Certified Prevention Specialist and Prevention Program Lead for Human Service Agency
- Tosa Two Heart, Director of Community Behavioral Health, Great Plains Tribal Leader's Health Board

Guests invited by Coalition members to support the broader discussion included:

- Kim Hansen, Mobile Crisis Response Team Lead, Southeastern Behavioral Health Care
- Multiple Public Safety Access Point site leads in the area of 911 response (see below for names and represented communities)

Support staff and external consultants in attendance included:

- Rachel Oelmann, Sage Project Consultants, LLC
- Nick Oyen, Sage Project Consultants, LLC
- Terresa Humphries-Wadsworth, 988 Planning Grant Manager, Education Development Center on behalf of Vibrant Emotional Health

Core 988 Planning & Implementation Considerations:

Oyen presented a high-level review of the eight core planning considerations, originally reviewed at the BHCRC's kick-off meeting in April. The primary intent of the project is to transition the National Suicide Prevention Lifeline (NSPL) to 988 and expand that capacity to further integrate and dispatch crisis response systems available within each area served by Lifeline-member centers. As a point of review, the Helpline Center (Sioux Falls, SD, who also manages 211) is the sole Lifeline-member center in South Dakota. Oyen also reminded the group that the core focus of the initial, short-term planning efforts is to plan for 988 implementation, but that this group will also be instrumental in the assessment, understanding, and capacity development of appropriate crisis response services throughout South Dakota.

Oyen reviewed the workgroup structure, designed to support deeper discussions on specific target areas in alignment with the eight core planning considerations. Several of the planning considerations are already considered complete (#3 #5, and #6) for the purpose and intent of the 988 planning process, and several others are being administered by state staff and Helpline Center staff directly.

Acknowledgement was made to the work groups for their contributions and time thus far.

Mental Health Crisis Response Today:

Oyen and Wolfgang facilitated a roundtable discussion on current processes for handling mental health crisis response.

- **Call Center Role.** Janet Kittams relayed on the behalf of Helpline Center that once a call is received via routing from NSPL, they will answer and respond accordingly based on needs relayed. Individuals that call the NSPL hotline range from those seeking information, those in crisis or with a family member or loved one in crisis, individuals who may feel they are in crisis but not in imminent danger to self or others, and everything in between. Most of the time (80%) the operators at the Helpline Center can de-escalate the crisis on the phone, connecting individuals to resources in their community as needed and offering follow-up services. Individuals who are assessed as in need of additional resources are connected to resources

directly. Right now, Helpline Center does not have access to dispatch mobile crisis teams; to dispatch those, a call is made to 911 in the community wherever that person is contacting from. Helpline Center shares the situation and circumstances, and from there 911 manages the response. When Helpline Center makes a phone call out to engage additional services, they try to stay on the call until those resources are on site and connections have been made. Helpline Center also does follow-up with individuals that call via NSPL to confirm they are or remain safe, that they can access resources, or to connect them with additional resources as needed.

- **911 Dispatch.** Maria King, the 911 Statewide Coordinator, introduced several key staff to support this discussion.

Aimee Chase presented on the current processes utilized by Metro Communications for 911 response in the Minnehaha County / Sioux Falls community. Metro Communications is an accredited Center of Excellence through Priority Dispatch. The protocol for handling mental health calls was reviewed, including priority level assignment (which dictates the level of response, which may include law enforcement, fire, hospital providers, EMS providers, and medical oversight). Law enforcement responds first and engages the mobile crisis response team as appropriate / at their discretion (law enforcement has protocols in this regard as well, which help them discern if crisis team mobilization would be helpful). Chase acknowledged that while calls are received from the Helpline Center, there is not currently the ability to have reciprocal information sharing. Noted that there remains opportunity to better share information between agencies to help increase access to care and become more efficient in that information sharing.

Mary Shoemaker from Pennington County then presented a high-level overview of their processes. Suicide calls are processed as a law enforcement call first unless circumstances with the individual's disposition merits an enhanced medical response.

Kent Jones on behalf of Brown County Communications provided an overview of their process, which is very similar to Metro Communications. Follow Emergency Medical Dispatch (EMD) protocols. Police department developed a new protocol (Jan 2020) for mental health calls that indicate law enforcement responds to each mental health call and makes the decision on site as to what additional resources are needed.

Cindy Gross (Pierre) reported that they, too, use a medical EMD protocol, but use a different dispatch technology compared to the other PSAPs contributing to the discussion. For a second or third priority suicide attempt, law enforcement is sent to the scene. Gross noted that they do have a mobile crisis unit in Pierre, but that it is not dispatched unless law enforcement requests them to go. Mobile team is not sent in until the scene is secured by law enforcement. Do use the local mobile team quite often. Pierre provides dispatch services for multiple counties.

Maria spoke to the 33 individual PSAPs --- 28 on the same technology platform. Mentioned that all the day-to-day operations are handled locally by the police departments or sheriff's offices, and that protocols vary.

- **Police Response**
Presented by Dave Kinser. Refer to slides. All new officers at Rapid City are fully certified in Crisis Intervention Team (CIT) training, and that they are working on training up the full police

force. Recently awarded a grant to build a collaborative crisis response, so have some additional researchers working with them to build that out. Kinser is able, in turn, to share that progress with the group. Kinser reported access to additional grant funds that have supported three (3) full time youth officers focused on crisis response and trauma. Both projects have implemented systematic follow-ups with impacted individuals.

Kinser was asked to comment on the unique programs happening in the Rapid City Police Department that others may consider as they refine their training protocols in crisis response. Kinser reported that the Law Enforcement Training Academy recently added 16 hours of CIT training as part of new officer certification process. In addition, Kinser advised that it would be ideal to have all officers have the full 40 hours of CIT. Kinser relayed that much of Rapid City's recent innovation has been supported by grant funding but advised that that solution is not feasible for all police departments in South Dakota. Many local level police departments are often limited in time and resources to seek/secure grant or other supplemental funding for special projects, and not every agency has the flexibility to support / manage grant work even if they could find the time to write for them. The largest opportunity for consistent, systemic training opportunities remains the Law Enforcement Training Academy.

In discussion, Staci Ackerman relayed that the South Dakota Sherriff's Association recently partnered with SD Law Enforcement Training, who employs the CIT Training Coordinator, with the goal of putting the CIT Training modules online. The online training is 24 hours long, with an additional 16 hours of scenario-based/in-person training to complete the program. Participating on other projects on virtual crisis care response; 18 counties were participating as of the end of 2020, and at the end of this legislative session Unified Judicial Systems (UJS) was approved to add some additional pilot sites (6 counties, 4 PDs, and a probation office). Lot of legislation that has been passed that will help us improve our response, and the Sheriff's Association is working with DSS, specifically DBH, to provide additional education on resources available and how to connect individuals in crisis to those resources.

In further discussion, the following points were noted:

- When you are working with someone in involuntary commitment, it falls to the sheriff's office to transport them to the next place and identifying that location for transport can be difficult. Anything we can do to keep individuals out of the jail setting is the ideal vision.
 - The Crisis Response work group discussions included mention of the ongoing e-care based pilot project modeled by Avera Health.
 - Rapid City PD has a department psychologist as well who helps provide input.
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- **Mobile Crisis Response**
Kim Hansen on behalf of Southeastern Behavioral Healthcare (SEBH) provided an update on the Mobile Crisis Response protocols deployed in Minnehaha and Lincoln counties. Law enforcement activated; for us to respond, the individual must meet probable cause – suicidal, homicidal, or mentally ill to the point they cannot take care of themselves. Team goes onsite to where the individual is located ---- goal is to develop a safety plan with them, which is based off a template and is designed to ultimately keep them safe. Individual and team member sign off on the form and both parties keep a copy --- if we do not come to an agreement on a satisfactory safety plan, SEBH asks if they would be willing to go to Avera BH for an assessment. If they say no, law enforcement may issue a mental health hold for involuntary assessment. The

team then loops back with both parties to keep everyone informed. Statutes were updated in 2011 to allow for exemption of liability, and that law enforcement can be excused from the scene if the mobile crisis team feels they have it in hand. Mobile team does follow-up ---- check in, offer resources, etc. If meeting where a person is at is not an option (e.g., at work, in a domestic situation) we do have a crisis care center we can meet with individuals at. Average 550 calls per year (all referral sources); our diversion rate is 94%. Very good success. Do participate in local CIT training; they help deliver those trainings with local law enforcement and work with NAMI.

- Amy Iversen reported on behalf of Capital Area's activities. Law enforcement makes a decision to call the on-call crisis response person and start by having a conversation about what is going on. Officer and counselor will decide what should happen next. Sometimes things can be resolved on the phone. Other times, our staff will go to the location where the individual is and try to work with them on a Safe at Home plan. Goal is to work with them in that crisis, a lot of times in the evenings, to keep them Safe at Home to prevent hospitalization, and get them lined up with services that day or the next day depending on timing. Counselors also go to the hospital ---- if someone presents to the ED, with a mental health issue, they will call the crisis response line and connect to those services. The hospital in Pierre also just recently implemented eCARE to access a psychiatrist ---- sometimes it results in a petition / commitment, but most of the time we can prevent a trip to Human Services Center (HSC). Admissions from Hughes and Stanley Co have reduced a lot because this program was implemented. It is very effective working through who really needs inpatient care, and who can benefit from community-based services. Go into the jail and do assessments there as well. It will be important to have this designed for what works for that community ---- what works in Pierre, would not work elsewhere. Currently cannot do much outreach to outlying communities due to lack of staff to travel / be at all those places but do what they can to link individuals to service by communication with those PDs/Sheriffs' offices.
- Thomas Otten reported on behalf of Avera Behavioral Health (ABH). The assessment program is 24/7 and serves as the front door to ABH. If someone comes on a hold, they run through the ED ---- go through this to get medical clearance; once the new psychiatric urgent care facility is open, they will be routed to that versus the ED. Sometimes they come in as a medical admission, not a behavioral health admission. Contact psychiatrist on call – determination is made for level of care. Most of the time they result in an inpatient admission.... Run about 6,500 admissions per year.
- Jeremy Johnson reported on behalf of HSC. System of care has highest levels of services available, but most restrictive environments for care. At HSC, we serve adolescents (12) to adults end of life. Short term and long-term programming. 86% of the people we serve come in on a mental health hold / involuntary commitment; on average, 1,300 admissions per year. Work with all counties and all tribal areas, and any out of state folks that find the need for emergency hold or commitment.

Technical Assistance Providers:

- Bre provided overview of the two projects that flow into / relate to the 988 considerations.
- HMA – Presented by David Bergman. Lee Repasch and Anh Pham joined. Based out of Michigan. Do all their work in the publicly funded health space. Refer to slides. Interviews will ask about needs from your organization's perspective, and recommendations moving forward.

- Tiff called attention to 988 being the “air traffic control” – and noted that Helpline Center would be a user of this system once developed.
- Mapped out current process for how to determine capacity ---- right now an email is sent out daily, and each provider responds by 10 am daily. The DBH team then uses that to inform bed.
- Thomas asked how the process will work ----- information sharing would be instantaneous in an ideal world, but that is a heavy lift for some organizations. The integration is not just difficult, its expensive. State staff noted that the project is not intended to be expensive ---- needs to be tactical and useful for organizations, so will encourage providers to help contribute ideas that make this system more efficient, timelier, etc. and incorporate that into the minimum requirements.
- Janet asked about the four states being used for comparison to South Dakota in the program evaluation ---- are all four of those using the bed registry system to facilitate live connections? There are only two states I know of that have the real time access. Tiffany relayed that Janet/team will need to be a key stakeholder in contributing to this process. Two states mentioned are AZ and GA. David noted his awareness of those two states was that it is more on dispatch of crisis response, not so much on bed availability.... but took the action to explore further.
- Guidehouse – presented by Jeff Meyers. Experience working in SD; three offices in state. Veronica Ross-Cuevas (Project Manager) and Peter Joyce (Project Coordinator) also introduced themselves. Discussed overlay of this work with successful implementation of 988 – coordination, capacity, funding, and communication. Guidehouse’s role is tied to the funding component. Work focuses on two main tasks: 1) research on fiscal strategies that the state could use to sustainability and effectively implement 988 services, and 2) crisis systems capacity and gap analysis.
 - Research cores include 988 Funding Options and Crisis Systems capacity and gap analysis
 - Work will account for how comparable states are structured and what resources they bring to bear (e.g., similar number of call centers, state’s Medicaid status (population served, expansion, etc.)
 - May interview stakeholders to fill in gaps or supplement secondary research

Visioning for Handling Mental Health Crisis in the Future:

Overview provided by Tiffany. Watched first video: <https://www.youtube.com/watch?v=GWZKW8PLlgQ>

- Noted that some of these things are available in SD, but not available statewide.
- Noted that these are the best practices nationwide (what we are looking at). And its important to examine how other states have approached crisis care in rural areas.
- Emphasized Anyone. Anywhere. Anytime. Need someone to call. Someone to respond. Somewhere to go. How do we stand that up equally, or as equally as we possibly can?
- Thomas commented that the video is powerful; need a system equipped to respond similar to a medical emergency. “We can do better by these folks.”
- Examine partnerships that are community based (volunteer fire fighters, EMS, CHWs, etc.)

Watched second video: <https://www.youtube.com/watch?v=ORq1MkODzQU>

- Highlighted AZ model
- Three key services – call center, community-based mobile crisis, immediate crisis facility (if needed)
- Key control points – robust information sharing network

- Mobile crisis team is done in dyads --- one MS level practitioner, and one BS level assistant
- Reactions
 - o Law enforcement – already taking a stressful position and adding more stress; they are being asked to do things in some cases they are not 100% trained in doing. Transition to this helps keep roles and responsibilities cleaner. Keeps law enforcement doing what they are trained to do.
 - o Documentation of case records from beginning to end is critical ---- we need to be able to share that information. 911 system has limitations now as well ---- looking to tie this together better (CAD to CAD interface).

Closing Remarks

Wolfgang thanked the coalition members for their willingness to participate and time commitment to this effort. Meeting adjourned.